

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

02932

Reg. Dist. No. 251

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Queen Anne</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Suddersville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Suddersville R.F. 6</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
		<u>Frank</u>				<u>Biddle</u>	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
		<u>March</u>		<u>15</u>		<u>1959</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>				<u>Sept 11-1892</u>	
9. AGE last birthday		If under 1 year		If under 24 hrs			
<u>58</u> yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Farmer</u>				<u>Farming</u>		<u>Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Biddle</u>				<u>May Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<u>no</u>				<u>✓</u>		<u>Mrs Sam Biddle (wife)</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>976x Suicide -</u>							
Antecedent cause(s) (b) <u>164c Shot himself with shot gun.</u>							
Conditions contributing to the death but not related to the disease or condition causing death. (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE				ADDRESS			
<u>W. Henry Fisher M.D.</u>				<u>Centerville Md</u>			
DATE SIGNED							
<u>3/17/51</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-17-51</u>		<u>Crumpton</u>		<u>Crumpton, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-17-51</u>		<u>Edgar L. Lane</u>		<u>Edgar L. Lane</u>		<u>Church Hill, Md.</u>	

100/105



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02934

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH- COUNTY <u>QUEEN ANNES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>(RURAL) GRASONVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>(RURAL) GRASONVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>(KENT NARROWS)</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>THOMAS</u> (Middle) <u>SAMUEL</u> (Last) <u>BONNEVILLE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 30 19 51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb. 28-1887</u>
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OSTER SHUCKER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OSTER</u>		11. BIRTHPLACE (State or foreign country) <u>Modestown Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Bonnerille</u>	
14. MOTHER'S MAIDEN NAME <u>Henrietta Justice</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>217-09-2191</u>	
16. SOCIAL SECURITY No. <u>217-09-2191</u>		17. INFORMANT AND ADDRESS <u>Hubbard Bonnerille, Baltimore, Md.</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CORONARY OCCLUSION

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from DOA, 19....., to....., 19....., that I last saw the deceasedalive on DOA, 19....., and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 5-1951</u>	<u>Richard A. Gentry, Md.</u>	<u>Grasonville, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr. 5-1951</u>	<u>Helen M. Aldridge</u>	<u>John D. Gentry, Md.</u>	<u>Grasonville, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690126

RECEIVED  
APR 12 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

02933

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Deeingsons Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Still Pond Md</u> COUNTY <u>Deeingsons</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hullington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond Md</u>	
TOWN <u>Hullington</u>		TOWN <u>Still Pond Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Still Pond Md</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary S Bonwill</u>		4. DATE OF DEATH <u>Mar 5 1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar 15 1881</u>	
9. AGE last birthday <u>69</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Charterville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>William Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Aldridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>William Bonwill</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Cancer of Bladderyear

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.none

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 22, 1951, to Mar 5, 1951, that I last saw the deceased alive on Mar 4, 1951, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE TIME OF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-6-51Edgar L. LaneStill Pond MdStill Pond, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 30 1951  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02935  
Reg. Dist. No. 254

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sadie</u>	(Middle) <u>M.</u>	(Last) <u>Champlin</u>
4. DATE OF DEATH	(Month) <u>3rd</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Mar. 18, 1867</u>
9. AGE last birthday <u>84</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>SAMUEL WALTERS</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. SULLIVAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Jessie Ireland - Grasonville</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>			<u>25 days.</u>
Antecedent cause(s) (b) <u>Diabetes mellitus</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 2, 1951</u> , to <u>Mar. 27, 1951</u> , that I last saw the deceased alive on <u>Mar. 25, 1951</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John T. Gibson, Jr. D.</u>		ADDRESS <u>Grasonville, Maryland</u>	
DATE SIGNED <u>Mar. 29, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>3/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>	LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>3/29/51</u>	REGISTRAR'S SIGNATURE <u>H. M. Aldridge</u>	24. FUNERAL DIRECTOR <u>Barton and Brothers, Centerville Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



RECEIVED  
APR 5 1951  
EL PASO, TEX.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02936  
Reg. Dist. No. 913

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	<u>MARY</u>	<u>ELLEN</u>	<u>CHANCE</u>
4. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	7. DATE OF BIRTH <u>August 19-1878</u>
8. AGE last birthday <u>77</u> yrs.	9. DATE OF DEATH <u>March 14</u> 19 <u>57</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. FATHER'S NAME <u>Russell Hook</u>	14. MOTHER'S MAIDEN NAME <u>Sarah Jane Boggs</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Heaven Chance Chester, Maryland</u>	18. MEDICAL CERTIFICATION	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

#### Immediate cause

422.1 Antecedent cause(s)  
108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) cerebral hemorrhage (thrombotic stroke) March 13, 1957  
(b) cerebral accident (hemorrhage) Oct. 1949  
lobar pneumonia March 1950  
(c) Arteriosclerosis Myocardial degeneration about 10 years

### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

chronic nephro-sclerosis + anemia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Febr. 16, 1951, to March 14, 1957, that I last saw the deceased alive on March 14, 1951, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

SIGNATURE

Theodor Sattelmayer M.D.

ADDRESS

Stevensville

March 15, 1951

23. BURIAL CREMATION REINTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 17-1951</u>	<u>Stevensville</u>	<u>Stevensville</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 17, 1951</u>	<u>Elizabeth Hoyer</u>	<u>Barton Bros</u>	<u>Centerville Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 22 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

03159

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queene Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queene Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Church Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Margaret</u>	(Middle) <u>Anne</u>	(Last) <u>Clark</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>About 7/18/65</u>
9. AGE last birthday <u>about 85 yrs.</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Goldsboro</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>John Clark--Church Hill, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Metabolic Heart Lesion</u>			<u>3 days</u>
Antecedent cause(s) (b) <u>Cerebral Hemorrhage</u>			<u>3 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Well</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 25, 1951</u> to <u>March 2, 1951</u> , that I last saw the deceased alive on <u>March 2, 1951</u> , and that death occurred at <u>11:00 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Edgar L. Lane</u>		DATE SIGNED <u>March 2, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 5</u>	NAME OF CEMETERY OR CREMATORY <u>Rich Neck</u>	LOCATION (City, town, or county) (State) <u>Near Church Hill, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-4-51</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 20 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02937

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
TOWN <u>Queenstown</u>		TOWN <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ALICE</u> (Middle) <u>PINDER</u> (Last) <u>COUNCELLOR</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 7, 1880</u>
9. AGE last birthday <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES E. PINDER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET SEWARD.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Carrie Biscoe, Queenstown, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

272X Immediate cause

(a)

CEREBRAL HEMORRHAGE

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

83a

(b)

DIABETES INSIPIDUS

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR. 22, 1951, to MAR. 26, 1951, that I last saw the deceasedalive on MAR. 25, 1951, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

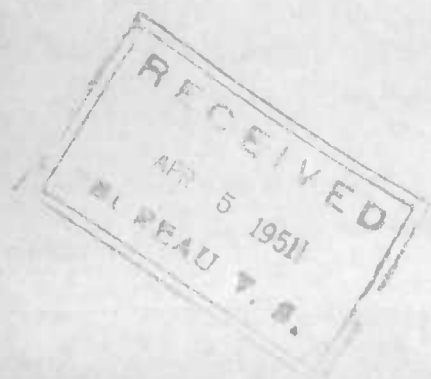
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

02938

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chestersville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Brownsville</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>OLIVER</u>	(Middle) <u>FREDERICK</u>	(Last) <u>JAMES</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>25</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 23-1900</u>
9. AGE last birthday <u>50</u> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Brownsville 2nd Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank James</u>		14. MOTHER'S MAIDEN NAME <u>Annie James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-4324</u>	
17. INFORMANT AND ADDRESS <u>Shedore James Chestersville Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Paralysis</u>			
Antecedent cause(s) (b) <u>Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>83d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/10</u> , 19 <u>51</u> , to <u>3/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>51</u> , and that death occurred at <u>6 PM</u> m., from the causes and on the date stated above.			
SIGNATURE <u>H. J. Matthews M.D.</u>		DATE SIGNED <u>3/27-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>March 28-51</u>	NAME OF CEMETERY OR CREMATORY <u>Brownsville</u>	LOCATION (City, town, or county) (State) <u>Queen Anne's Md</u>
DATE REC'D BY LOCAL REG. <u>3-27-1951</u>	REGISTRAR'S SIGNATURE <u>Elmer Armstrong</u>	24. FUNERAL DIRECTOR <u>Barton Bros</u>	ADDRESS <u>Chestersville Md</u>

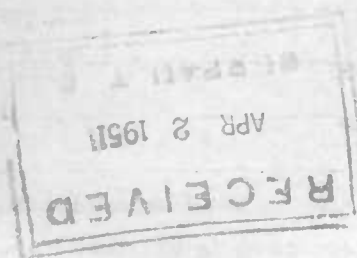
970679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02939

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester (Rural)</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester (Rural)</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Lizzie</u> (Middle) <u>Watson</u> (Last) <u>Jones</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>October 26-1901</u> - 58 yrs.
9. AGE last birthday <u>58</u> If under 1 year Months <u>3</u> Days <u>3</u> If under 24 hrs. Hours <u>3</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster shipper</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ludwig Watson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Richard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>222-05-1740</u>	
17. INFORMANT <u>George H. Jones</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>	<u>March 29, 1951</u>
Antecedent cause(s) (b) <u>Arteriosclerosis, angina pectoris</u>	<u>several</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive cardio-vascular disease</u>	<u>years</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 24, 1951, to March 24, 1951, that I last saw the deceased alive on March 24, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE Theodor Sattelmair, M.D. ADDRESS Stevensville DATE SIGNED March 29, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>April 24, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. John Baptist Church</u>	LOCATION (City, town, or county) <u>Painter, Pa.</u>	(State) <u>Pa.</u>
DATE REC'D BY LOCAL REG. <u>3/31/51</u>	REGISTRAR'S SIGNATURE <u>A. H. Reeves</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>		

Elizabeth Hynes 690126

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 9 1951  
BUREAU V. C.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

02940

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>24.60</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Shampos Creek</u>	
3. NAME OF DECEASED (Type or Print) <u>SALLIE</u> (First) <u>WARNER</u> (Middle) <u>JONES</u> (Last)		4. DATE OF DEATH <u>March</u> (Month) <u>26</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 17-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Sabek Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Warner</u>		14. MOTHER'S MAIDEN NAME <u>Dorot Kusa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Corvill Tolson, Stevensville, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) acute meningia

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) chronic pyelitis + nephritis (nephro-sclerosis)

(c) Arteriosclerosis senility

##### INTERVAL BETWEEN ONSET AND DEATH

March 24, 1951

Several years

10 years

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Mitral regurgitation

20 years

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1930, to March 26, 1951, that I last saw the deceased alive on March 26, 1951, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>March 29</u>		<u>Stevensville</u>		<u>Stevensville</u>		<u>Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>March 30, 1951</u>		<u>Elizabeth Foster</u>		<u>Barton B. Co.</u>		<u>Stevensville, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
of 21 shown on:

FILE No. G 132 APR 9 1951

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

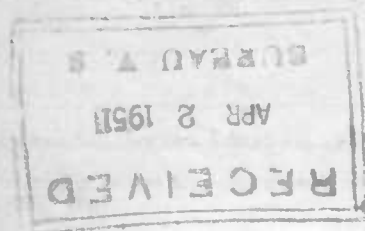
02941

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kent Centerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>WILBERT</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 25-1884</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond 24 Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wilbert Wilmer</u>		14. MOTHER'S MAIDEN NAME <u>Nancy King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Henrietta Hall Centerville Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>900.0 Convulsions - of Cerebral origin</u>			
Antecedent cause(s) <u>186a from Fracture of skull from Fall</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE <u>accident</u>		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>fell all way down cellar steps striking</u>			
22. I hereby certify that I attended the deceased from <u>Feb 16</u> 19 <u>51</u> , to <u>March 25</u> 19 <u>51</u> , that I last saw the deceased alive on <u>March 24</u> 19 <u>51</u> , and that death occurred at <u>12:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>W. J. Fisher M.D.</u>		ADDRESS <u>Centerville Md</u>	
DATE SIGNED <u>3/27/51</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 27-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Christified</u>		LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3-27-1951</u>		24. FUNERAL DIRECTOR <u>Barton Bros Centerville Maryland</u>	

820105





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 253

02942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
TOWN <u>Chester</u>		TOWN <u>Chester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Homer</u> (Middle) <u>Andrew</u> (Last) <u>Lee Jr.</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Febr. 27, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>21</u> yrs. If under 1 year Months <u>21</u> Days <u>21</u> Hours <u>21</u> Mins. If under 24 hrs. Months <u>21</u> Days <u>21</u> Hours <u>21</u> Mins.
11. BIRTHPLACE (State or foreign country) <u>Chester Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Homer Andrew Lee</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Madeline Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) congenital debility

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) due to chronic alcoholism of mother(c) congenital leues?

## INTERVAL BETWEEN ONSET AND DEATH

sincebirthII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Febr. 27, 1951, to March 20, 1951, that I last saw the deceased alive on March 19, 1951; and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>March 21/1951</u>	<u>Union m. C.</u>	<u>Chester Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar. 21/1951</u>	<u>Elizabeth Hopper</u>	<u>W. J. Mills</u>	<u>Stevensville Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02943

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u> TOWN <u>Millington</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> TOWN <u>Stevensville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ANNIE</u> (First) <u>L.</u> (Middle) <u>LEGG</u> (Last)		4. DATE OF DEATH <u>March</u> <u>15</u> 19 <u>51</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 15, 1871</u>	9. AGE last birthday <u>79</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>Thomas E. Erickson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Weedman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. Alta Robbins, Millington, MD.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

10 years

Antecedent cause(s)

(b) Arteriosclerosis70 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.Intestinal Obstruction2 weeks

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>—</u>	(CITY OR TOWN) <u>—</u>	(COUNTY) <u>—</u>	(STATE) <u>—</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>		

22. I hereby certify that I attended the deceased from 3/7/51, 1951, to 3/15/51, 1951, that I last saw the deceased alive on 3/14/51, 1951, and that death occurred at 11:20 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. N. HamiltonM.D.Millington, MD.3/16/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	LOCATION (City, town, or county) <u>Stevensville</u>	(State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>3-16-51</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Edward Fellows, Millington, MD.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 30 1951  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Janie</u> (Middle) <u>Mc</u> (Last) <u>Ginnis</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>51</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/1/1867</u>
9. AGE last birthday <u>83</u> yrs.		10. If under 1 year Months <u>3</u> Days <u>27</u> Hours <u>51</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Caroline County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Foulkner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Robert Mc Ginnis Sudlersville, Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

241x Immediate cause (a) Bronchial Pneumonia

107 Antecedent cause(s) (b) Exposure

(c) Bronchial Asthma

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>W</u>	19b. MAJOR FINDINGS OF OPERATION <u>Fracture</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>W</u> (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>W</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) <u>W</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1951, to July 27, 1951, that I last saw the deceased alive on July 25, 1951, and that death occurred at 5:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/30/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Busic</u>	LOCATION (City, town, or county) (State) <u>Near Sudlersville, Md.</u>
DATE REC'D BY LOCAL REG. <u>3/29/51</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>R.B. Rawlings Greensboro, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH

1917-1918

STATE OF DEATH

RECEIVED

APR 24 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>ROLAND</u> (Middle) <u>WHALEN</u> (Last) <u>MORGAN</u>		4. DATE OF DEATH (Month) <u>MAR</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb 18, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>58</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Hackett Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Lucie Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Two Roland Morgan, Queen Anne Isl.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Kachexia</u>		
Antecedent cause(s) (b) <u>Carcinoma of the bones and liver</u>		<u>1 year</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of the prostate gland</u>		<u>18 mos</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 43, 1943, to March 25, 1951, that I last saw the deceased

alive on March 25, 1951, and that death occurred at 11:10 p.m., from the causes and on the date stated above.

SIGNATURE Dr. J. L. Ledore (Degree or title) M.D. ADDRESS Queen Anne Md DATE SIGNED March 24, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Mar. 28, 1951 NAME OF CEMETERY OR CREMATORY Greenmount LOCATION (City, town, or county) Hillboro, Ind (State)

DATE REC'D BY LOCAL REG. 3-27-1951 REGISTRAR'S SIGNATURE Oliver Armstrong 24. FUNERAL DIRECTOR J. Virgil Moore, Sr., Denton, Del. ADDRESS

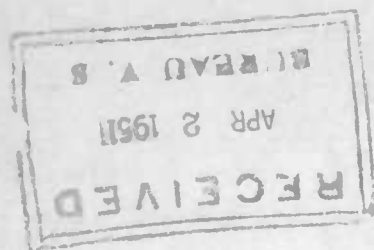
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

02945

Reg. Dist. No. 252

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville (Rural)</u>	
TOWN <u>Centerville</u>		TOWN <u>Centerville (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>FANNIE ELIZABETH SCHELHOUSE</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>3 1 1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 15 - 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Queenstown Maryland</u>
13. FATHER'S NAME <u>Thomas C. Meredith</u>		14. MOTHER'S MAIDEN NAME <u>Hester Ann Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
(If yes, give year or dates of service)		17. INFORMANT AND ADDRESS <u>Miss Hester Meredith, Centerville, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Mitral Regurgitation

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF INJURY	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from Nov 16, 1949, to March 1, 1951, that I last saw the deceasedalive on Feb 28, 1951, and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 3/51</u>	<u>Centerville</u>	<u>Centerville</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-3-1951</u>	<u>Clara W. W. W. W.</u>	<u>Barton Bras</u>	<u>Centerville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

STANDARD TELEPHONE & TELEGRAPH CO.  
RECEIVED NO. 100-100000

RECEIVED  
MAR 5 1951  
BUFFALO, N. Y.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02946 253

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>EFFIE</u> <u>VIRGINIA</u> <u>SULLIVAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH</u> <u>7</u> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 2, 1890</u>
9. AGE last birthday <u>60</u> yrs.		10. AGE last birthday (If under 1 year) (If under 24 hrs) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN WHEELER</u>		14. MOTHER'S MAIDEN NAME <u>MARY NOAH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>THOMAS JONES, CHESTER, MD.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause

(a) CHRONIC MYOCARDITIS

15 YRS.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) HYPERTENSION

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

ABDOMINAL TUMOR

## 19a. DATE OF OPERATION

NONE

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR. 6, 1951, to MAR. 7, 1951, that I last saw the deceasedalive on MAR. 6, 1951, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 7, 1951Elizabeth HoxterWilliam O. Wilson1050 Kenting Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02947 254

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Delmar's neck</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HARRIETT</u>	<u>MARIE</u>	<u>THOMAS</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>March</u>	<u>19</u>	<u>1951</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Sept 4-1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>None</u>		<u>None</u>	<u>in Queenstown Maryland</u>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY	
<u>Samuel B Thomas</u>		<u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
<u>None</u>		<u>None</u>	<u>Mr. Samuel B Thomas Queenstown Md</u>

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Gastro-Enteritis</u>			<u>1 week.</u>
Antecedent cause(s) (b) <u>5710 Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
			(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 12</u> , 1951, to <u>March 19</u> , 1951, that I last saw the deceased alive on <u>March 15</u> , 1951, and that death occurred at <u>5:00</u> m., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>W. Henry Fisher M.D.</u>		<u>3/19-51</u>	
ADDRESS			
<u>Centerville Md.</u>			
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 20-51</u>	<u>Chesters</u>	<u>Centerville Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Mar. 20-51</u>	<u>Helen M. Aedridge</u>	<u>Barton Barr</u>	<u>Centerville Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

10904023540V

UNITED STATES DEPARTMENT OF JUSTICE

THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

RECEIVED  
MAY 26 1961  
U.S. DEPT. OF JUSTICE



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ingleside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ingleside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John W.</u>	(Middle)	(Last) <u>Thompson</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>16</u>	(Year) <u>51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/18/1877</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Susian Satterfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-16-3311</u>	
17. INFORMANT AND ADDRESS <u>Edith Thompson Ingleside, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Diabetic Gangrene of Left Foot &amp; Buckle</u>			
Antecedent cause(s) (b) <u>Diabetic Mellitus</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Prostate Gland</u>			
19a. DATE OF OPERATION <u>W</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>W</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 19 <u>50</u> , to <u>July 16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>51</u> , and that death occurred at <u>4:35 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>@ M. J. T. Satterfield M.D.</u>		ADDRESS <u>Fudlersville, Md.</u> DATE SIGNED <u>3/17/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/20/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Busick</u>	LOCATION (City, town, or county) (State) <u>Near Barclay, Md.</u>
DATE REC'D BY LOCAL REG. <u>3/19/1951</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Raymond B. Rawlings</u>	ADDRESS <u>Shawboro</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105

# MARYLAND STATE DEPARTMENT OF HEALTH

1001 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. No. 100

1. Name of deceased (Print or write full name)  
STATE

2. Sex (Print or write)

3. Date of death (Print or write full date)

4. Age

5. Cause of death (Print or write full cause)

6. Place of death (Print or write full place)

7. Date of death

8. Time of death

9. Name of physician (Print or write full name)

10. Name of hospital (Print or write full name)

11. Name of nurse (Print or write full name)

12. Name of doctor (Print or write full name)

13. Name of pathologist (Print or write full name)

14. Name of coroner (Print or write full name)

15. Name of registrar (Print or write full name)

16. Name of undertaker (Print or write full name)

17. Name of funeral home (Print or write full name)

18. Name of cemetery (Print or write full name)

19. Name of burial place (Print or write full name)

20. Name of interment place (Print or write full name)

21. Name of crematorium (Print or write full name)

22. Name of other place (Print or write full name)

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58. Name of other place (Print or write full name)

RECEIVED  
MAR 30 1951  
BUREAU V. B.